| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155198 | A. BUILDING 01<br>B. WING | 03/05/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MARQUETTE | 8140 TOWNSHIP LINE RD<br>INDIANAPOLIS, IN 46260 |

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| K0000 | A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).<br><br>Survey Date: 03/05/12<br><br>Facility Number: 000105<br>Provider Number: 155198<br>AIM Number: NA<br><br>Surveyor: Mark Caraher, Life Safety Code Specialist<br><br>At this Life Safety Code survey, Marquette was found not in compliance with Requirements for Participation in Medicare, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.<br><br>This two story building with a basement was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridor and resident rooms. The facility has a capacity of 102 and had a census of 89 at the time of this survey. | K0000 | The creation and submission of this plan of correction does not constitute as an admission of any conclusion set forth in the statement of deficiencies or any violation of regulation(s). | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/08/12.<br><br>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following: | | | |

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| K0017 SS=E | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5<br>Based on observation and interview, the facility failed to ensure 1 of 3 open use areas on the second floor was separated from the corridor by smoke resistant partitions capable of resisting the passage of smoke, or met an Exception. LSC 19.3.6.1, Exception # 1: Smoke compartments protected throughout by an approved, supervised automatic sprinkler system shall be permitted to have spaces unlimited in size open to the corridor, provided the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, or the smoke | K0017 | **K017**<br><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**<br>The Family Room involved in this alleged deficient practice has been protected throughout by four (4) quick response sprinklers and was promptly equipped with a smoke detector upon identification of this concern. See “Attachment K017A, FR Smoke Head”.<br><br>**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**<br>All residents have the potential to be affected by the alleged | 04/04/2012 |

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| | compartment in which the space is located is protected throughout by quick response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. This deficient practice could affect any resident, staff or visitor in the vicinity of the Family Room by Room 217 on the second floor.<br><br>Findings include:<br><br>Based on observation with the Plant Director during a tour of the facility from 11:40 a.m. to 2:20 p.m. on 03/05/12, the Family Room by Room 217 on the second floor is open to the corridor due to the lack of corridor walls and doors and is not protected by an electrically supervised automatic smoke detection system. Exception #1(b) of LSC 19.3.6.1 was not met because the Family Room is not protected by an electrically supervised automatic smoke detection system, or protected throughout by quick response sprinklers. Based on interview at the time of observation, the Plant Director acknowledged the Family Room by Room 217 is open to the second floor corridor and is not provided with smoke detectors | | deficient practice. The Family Room involved in this alleged deficient practice was promptly equipped with a smoke detector upon identification of this concern.<br><br>**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**<br>A full inspection of the Health Center was performed to ensure that this alleged deficient practice was isolated to the area identified during the survey. The Family Room involved in this alleged deficient practice was promptly equipped with a smoke detector upon identification of this concern.<br><br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**<br>Maintenance personnel will randomly inspect the Health Center smoke heads for proper placement and function monthly at a minimum for three months and quarterly at a minimum unless determined by the QA Committee. | |

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| | or quick response sprinklers.<br><br>3-1.19(b) | | | |

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| K0038 SS=F | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1<br><br>Based on observations and interview, the facility failed to ensure 7 of 8 exit door electromagnetic locks remained unlocked while the fire alarm was activated. LSC 19.2.1 requires every aisle, passageway, corridor, exit discharge, exit location, and access to be in accordance with Chapter 7. LSC 7.2.1.6(a) requires doors with special locking arrangements such as electromagnetic locks to unlock upon actuation of an approved fire alarm system installed in accordance with LSC 9.6. This deficient practice affects all residents, staff and visitors needing to exit the facility from the first and second floors.<br><br>Findings include:<br><br>Based on observations with the Plant Director during a tour of the facility from 11:40 a.m. to 2:20 p.m. on 03/05/12, the electromagnetic locks on all second floor and all first floor exits, except for the main entrance, did not release and remain unlocked when the fire alarm was activated at 1:52 p.m. Based on interview at the time of the observations, the Plant Director acknowledged the the electromagnetic locks on all second floor | K0038 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Previously, any detection of smoke would trigger alarms in all separate areas of Marquette. Late 2011, contractors were hired to segregate the alarms in each area in order to alert only those in potential danger. At the time of this survey, contractors still had the SNF area exit doors triggered to release when smoke was detected in the Assisted Living area. Upon identification of the deficiency, contractors properly programmed the electromagnetic locks to unlock upon actuation of the fire alarm system. See Attachment K038A, Door Work Order. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents residing in the Health Center have the potential to be affected by the alleged deficient practice. Upon identification of the deficiency, contractors properly programmed the electromagnetic locks to unlock upon actuation of the fire alarm system. **What measures** | 04/04/2012 |

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| | and all first floor exits, except for the main entrance, did not release and remain unlocked when the fire alarm was activated.<br><br>3.1-19(b) | | **will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** During random fire drills, maintenance personnel will randomly check to ensure that doors equipped with electromagnetic locks unlock upon actuation of the fire alarm system. This validation will be documented on facility fire drill form. See Attachment K038B, Fire Drill Form. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Administration will inspect and sign off on each fire drill form for proper completion or identification of concerns. Fire drills will occur randomly once per week through April 27, 2012, and then continue per required schedule unless determined by QA review. | |

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| K0045 SS=E | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8<br>Based on observation and interview, the facility failed to ensure lighting for 2 of 5 exit means of egress were arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. This deficient practice could affect any resident, staff or visitor needing to exit the facility from the Lower Level Physical Therapy Exit and the employee parking lot exit.<br><br>Findings include:<br><br>Based on observation with the Plant Director during a tour of the facility from 11:40 a.m. to 2:20 p.m. on 03/05/12, the exit means of egress from the Lower Level Physical Therapy Exit and the employee parking lot exit are each equipped with one light fixture with one bulb. Based on interview at the time of observation, the Plant Director acknowledged only one light fixture with one bulb was provided at the Lower Level Physical Therapy Exit and the employee parking lot exit. | K0045 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** New fixtures have been installed at the observed 2 of 5 exits involved in the alleged deficient practice so the failure of any single bulb will not leave the area in darkness. See "Attachment K045A, Egress Lighting". **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by the alleged deficient practice. New fixtures have been installed at the observed 2 of 5 exits involved in the alleged deficient practice so the failure of any single bulb will not leave the area in darkness. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** New fixtures have been installed at the observed 2 of 5 exits involved in the alleged deficient practice so the failure of any single bulb will | 04/04/2012 |

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| | 3.1-19(b) | | not leave the area in darkness.<br>**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**<br>Random inspection of egress lighting around the Health Center will take place three (3) times weekly through April 27, 2012, then weekly for four (4) weeks, and then monthly if determined by QA review. See “Attachment K045B, Egress Lighting Audit”. | |

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| K0048 SS=E | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1<br>Based on record review and interview, the facility failed to include the use of kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility. LSC 19.7.2.2 requires written health care occupancy fire safety plans shall provide for the following:<br>(1) Use of alarms<br>(2) Transmission of alarm to the fire department<br>(3) Response to alarms<br>(4) Isolation of fire<br>(5) Evacuation of immediate area<br>(6) Evacuation of smoke compartment<br>(7) Preparation of floors and building for evacuation<br>(8) Extinguishment of fire<br>This deficient practice affects any resident, staff and visitors in the vicinity of the kitchen.<br><br>Findings include:<br><br>Based on a review of the facility's written fire safety plan titled "Disaster Preparedness Manual: Fire" during record review with the Plant Director and the Administrator from 9:40 a.m. to 11:40 a.m. on 03/05/12, the fire safety plan did not address the use of ABC type fire | K0048 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The Health Center does have a written plan for the protection of all patients and for their evacuation in the event of an emergency. In response to the alleged deficient practice, the plan has been modified to include the following statement: "The proper extinguisher should be used for the proper fire. ABC extinguishers will handle most fires encountered in our buildings. An uncontrollable grease fire in the kitchen can be controlled by manually activating the hood suppression system (if not activated automatically) and then by using the K extinguisher located adjacent to the deep fryer as a backup." **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by the alleged deficient practice. In response to the alleged deficient practice, the plan has been modified to include the following statement: "The proper extinguisher should be used for the proper fire. ABC | 04/04/2012 |

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| | extinguishers and the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on interview at the time of record review, the Plant Director and the Administrator acknowledged the written fire safety plan for the facility did not include kitchen staff training to activate the overhead hood extinguishing system to suppress a fire before using either the ABC type fire extinguisher or the K class fire extinguisher.<br><br>3.1-19(b) | | extinguishers will handle most fires encountered in our buildings. An uncontrollable grease fire in the kitchen can be controlled by manually activating the hood suppression system (if not activated automatically) and then by using the K extinguisher located adjacent to the deep fryer as a backup." **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All maintenance and food service personnel will be educated regarding the updated policy. Continuing education will occur with newly hired maintenance and food service personnel and annually thereafter for all maintenance and food service personnel. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Quality Assurance Committee will review the fire safety plan for compliance and make updates as indicated by April 4, 2012. | |

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| K0144 SS=F | NFPA 101<br>LIFE SAFETY CODE STANDARD<br>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.<br><br>Based on record review and interview, the facility failed to ensure a complete written record of weekly inspections of the starting batteries for the emergency generator was maintained for 52 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on review of "Health Center | K0144 | **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** In response to the alleged deficient practice, the Generator Test Log has been modified to allow for documentation of Battery Visual Inspection and Electrolyte Levels. See Attachment K144, Generator Log. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by the alleged deficient practice. In response to the alleged deficient practice, the Generator Test Log has been modified again to allow for documentation of Battery Visual Inspection and Electrolyte Levels. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All maintenance personnel will be educated regarding the updated Generator Log. Continuing education will occur with newly hired maintenance personnel as | 04/04/2012 |

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| | Generator Test Log" documentation with the Plant Director and the Administrator during record review from 9:40 a.m. to 11:40 a.m. on 03/05/12, weekly emergency generator starting battery inspection records for the fifty two week period from 03/07/11 through 02/27/12 was not recorded. Based on interview at the time of record review, the Plant Director acknowledged weekly emergency generator starting battery inspection records for the fifty two week period from 03/07/11 through 02/27/12 was not recorded.<br><br>3.1-19(b) | | to proper completion of this log as determined by their job responsibilities. The Plant Director and/or his designee will be responsible for proper completion of the Health Center Generator Log. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Health Center Administrator and Plant Director will review the Health Center Generator Test Log on a weekly basis through April 27, 2012, and then monthly thereafter unless continued weekly inspection is determined by the QA Committee. | |